Francis A. Bax, MS, LMHC, LPC, CASAC-Master
BEHAVIOR HEALTH COUNSELOR
203 Robinson Street
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INDIVIDUAL CLIENT INFORMATION INTAKE FORM

*****THIS INFORMATION WILL BE KEPT COMPLETELY CONFIDENTIAL*****

(PLEASE PRINT CLEARLY!)

Today's Date: _____

Name: _____ Birthdate_____ Age _____

Sex: ☐ MALE ☐ FEMALE

Address_____

Street_____ City_____ State_____ Zip_____

Home Phone (___) _____Work Phone (___) _____

Can a message be left with you? ☐ YES ☐ NO

Best Place to Leave a Message (___) _____

Who were you referred by? / How did you hear about me?

_____

Level of Education: ☐ HS ☐ College ☐ Other _____

Place/Type of Employment_____ How long? _____ Full or Part time? _____

If unemployed, how long: _____

What type of work did you do? _____

Marital Status ☐ Married # of years____;

☐ Divorced # of years ___; ☐ Widowed____# of years____;

☐ Single ☐ Committed ☐ Domestic Relationship

Living with_____

Spouse's Name_____

Spouse's Occupation_____

In Case of Emergency Notify: _____ Phone: _____

Relationship: _____

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO

If yes, what were the circumstances? Please include dates:

_____

_____

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When was your last full physical exam? _____

Any physical issues? _____

Please check off any of the following health problems you may have or previously had:

☐ Diabetes	☐ Heart Murmur	☐ Chron's Disease
☐ High Blood Pressure	☐ Pneumonia	☐ Colitis
☐ High Cholesterol	☐ Pulmonary Embolism	☐ Anemia
☐ Hypothyroidism	☐ Asthma	☐ Jaundice
☐ Goiter	☐ Emphysema/COPD	☐ Hepatitis
☐ Cancer	☐ Stroke	☐ Stomach/Peptic Ulcer
☐ Leukemia	☐ Cataracts	☐ Tuberculosis
☐ Angina	☐ Kidney Disease	☐ HIV/AIDS
☐ Heart Problems	☐ Kidney Stones	☐ Hearing Loss

How have these health issues impacted you?

_____

_____

_____

Sleeping issues? ☐ YES ☐ NO

How many hours of sleep to you get each evening? _____

List any medications you are presently taking and dosage:

_____

_____

_____

_____

Any family members (include parents, grandparents, aunts, or uncles with emotional issues (depression, anger, anxiety, etc.)

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_____

_____

Any problems with Alcohol? _____ drugs? _____

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Do you have current thoughts of suicide? ☐ YES ☐ NO

If so, do you have a plan? ☐ YES ☐ NO

Do you have resources to carry out a suicide? ☐ YES ☐ NO

Have you ever had thoughts about suicide? ☐ YES ☐ NO

Have you ever attempted suicide? ☐ YES ☐ NO

If yes, how many times? _____

How do you spend time relaxing?

_____

_____

Have you ever had concern about eating habits? ☐ YES ☐ NO

Please state the reasons for seeking counseling at this time?

_____

_____

_____

_____

Have you ever been in counseling before? ☐ YES ☐ NO

For how long? _____ Was it helpful for you? ☐ YES ☐ NO

Please explain how it was helpful:

_____

_____

Please explain how it wasn't helpful:

_____

_____

Please explain where you left off in your therapy:

_____

_____

Please check off the problems that you're having in your life right now or previously:

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Did you freely choose to go for counseling? ☐ YES ☐ NO

if no, please explain who wanted you or made to go for counseling and their reasoning:

- ☐ Depression
- ☐ Anxiety
- ☐ Stress
- ☐ ADHD
- ☐ Post-Traumatic Stress/PTSD
- ☐ Headaches
- ☐ Nervousness
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shyness
- ☐ Stomach Trouble
- ☐ Inability to Relax
- ☐ Unhappiness
- ☐ Fatigue
- ☐ Legal Matters and Issues
- ☐ Problems with Self Control
- ☐ Poor Appetite
- ☐ Concentration Problems
- ☐ Bad Temper
- ☐ Ambition
- ☐ Health Problems
- ☐ Death of a Spouse/Partner
- ☐ Major Injury
- ☐ Bad Break Up
- ☐ Anger
- ☐ Poor Memory
- ☐ Decision Making
- ☐ Insomnia
- ☐ Nightmares
- ☐ Separation
- ☐ Poor Energy
- ☐ Feeling Inferior
- ☐ Illicit Drug Use
- ☐ Alcohol Use Problems
- ☐ Cigarette Smoking
- ☐ Loneliness
- ☐ Marriage/Relationship Issues
- ☐ Allergies
- ☐ Suicidal
- ☐ Sexual Problems
- ☐ Work
- ☐ Eating Issues
- ☐ Problems with Home
- ☐ Problems with Friends
- ☐ Traumatic Brain Injury
- ☐ Death of a Family Member
- ☐ Financial Issues
- ☐ Job Dissatisfaction/Bullying at Work
- ☐ Aging and Mortality
- ☐ Financial Issues
- ☐ My Appearance/Looks
- ☐ My Future/Ambitions
- ☐ History of Sexual Abuse
- ☐ History of Physical Abuse
- ☐ History of Emotional Abuse
- ☐ History of Trauma
- ☐ Career Choices
- ☐ Weight/Body Image Issues
- ☐ Mood Swings
- ☐ Fears
- ☐ Poor Self-Esteem
- ☐ Worries
- ☐ Sexual Orientation
- ☐ Athletic Performance
- ☐ Public Speaking Issues
- ☐ Motivation Problems
- ☐ Divorce
- ☐ My Thoughts
- ☐ Autism Spectrum Issues
- ☐ Major Illness
- ☐ Relocation to/from Elsewhere
- ☐ Job Loss

_____

_____

_____

_____

Are you bound by a legal mandate to attend counseling? ☐ YES ☐ NO

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I hereby give consent for evaluation and treatment. It is agreed that either of us may discontinue the evaluation and treatment at any time and that I am free to accept or reject the treatment provided. I hereby affirm that I I authorize services for the child under the terms of this agreement.

Signature: _____ Date: _____